MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Southeast Health Services, Inc. P.O. Box 170336 Dallas, TX 75217	MDR Tracking No.: M4-03-7541-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Zurich American Insurance Co. Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 2230098082

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
08/07/02	**08/07/02**	**97799-JA**	**$629.00**	

PART III: REQUESTOR'S POSITION SUMMARY

The requestor did not provide a position summary or respond to the request for additional information.

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 09/02/03 states in part, "…In the Medical Fee Guidelines, when items are to be billed in time increments, the Guidelines **expressly** state the items are to be billed in time increments. In this instance, the provder bills in time increments and does not produce any evidence to justify charging $268 per hour. The report include a considerable amount of canned language and there is not justification for including driving time, especially at $238 per hour. There is not sufficient DOP to justify three hours for this evaluation. There is no comparable billing procedure in the Guidelines. The billing in dispute has been paid at a fair and reasonable rate in accordance with TWCC guidelines, policies, and rules, and the Texas Labor Code. Carrier has determined that based upon its database $175.00 represents fair and reasonable reimbursement for this service. Using Respondent's time increment method, that comes to $58.33 per hour. The provider must therefore prove that the reimbursement received is not fair and reasonable…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 97799-JA for date of service 08/07/02 denied as "M – No MAR". The requestor billed $804.00 for this date of service; the respondent paid $175.00 leaving a balance of $629.00. Per Rule 133.1(a)(8) the requestor did not submit convincing evidence to support the amount billed was fair and reasonable and met the standards set out in Rule 413.011 of the Texas Labor Code. Additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
8/7/2002	97799-JA	$629.00	$0.00				
				Total Left Column:			$629.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

	Marguerite Foster	01-13-05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____